



**LICENSE VERIFICATION AFFIDAVIT  
FOR DRUG DISTRIBUTOR  
(Indiana Code 25-26-14, 856 IAC 3)**

State Form 47229 (9-95)

Health Professions Bureau  
Indiana Board of Pharmacy

**INSTRUCTIONS:** Return completed form to requesting firm.

Name of business			
Address of business (number and street, city, state, ZIP code)			
Corporate name (if different from business name)			
Type of operation (check all that apply)			
<input type="checkbox"/> Full Service Wholesaler	<input type="checkbox"/> Retail or Hospital Pharmacy Conducting Wholesale Distribution	<input type="checkbox"/> Distributor's Warehouse	
<input type="checkbox"/> Manufacturer	<input type="checkbox"/> Private-label Distributor	<input type="checkbox"/> Chain Drug Warehouse	
<input type="checkbox"/> Repacker	<input type="checkbox"/> Own-label Distributor	<input type="checkbox"/> Independent Wholesale Drug Trader	
<input type="checkbox"/> Medical Gas Seller/Distributor/Relabeler	<input type="checkbox"/> Manufacturer's Warehouse	<input type="checkbox"/> Other (specify)	
Type of drugs distributed (check all that apply)			
<input type="checkbox"/> Controlled Substances DEA Number _____	<input type="checkbox"/> Non-prescription Drugs	<input type="checkbox"/> Non-controlled Prescription Drugs	
		<input type="checkbox"/> Other (specify)	
I hereby authorize the _____ to furnish to the Indiana Board of Pharmacy, the information requested below.			
Signature of applicant (corporation, partnership, individual owner)			

DO NOT WRITE BELOW THIS - FOR LICENSING AGENCY ONLY			
License number	License status	Date license issued (month, day, year)	Date license expires (month, day, year)
Has this license been encumbered in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of encumbrance (if any) <input type="checkbox"/> Revoked <input type="checkbox"/> Surrendered <input type="checkbox"/> Limited <input type="checkbox"/> Suspended <input type="checkbox"/> Restricted <input type="checkbox"/> Probation	Please attach copies of any pertinent legal documents.	
<b>Use reverse side of this form for explanations, if necessary.</b>			
Has the applicant been convicted of any federal, state or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances? (if Yes, explain)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the applicant furnished any false or fraudulent material in any applications made in connection with drug manufacturing or distribution? (if Yes, explain)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has any inspections of the applicant resulted in deficiency ratings? (if Yes, explain)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has applicant met all licensing requirements of your state? (if No, explain)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Signature of state official			Date signed (month, day, year)
Title of state official			State